# First Report of Injury Filing Instructions

Completed ***First Report of Injury (FROI) Forms*** are to be faxed or e-mailed within 24 hours of the accident to our Workers Compensation carrier below:

**Berkley Risk**
**222 South Ninth Street**
**Suite 2700**
**Minneapolis, MN 55402**

**FAX: (866) 340-5549**
**or**
**E-mail: bracfroi@berkleyrisk.com**

**DO NOT send the completed *First Report of Injury Form* to the State of Minnesota. Berkley Risk will administer that process.**

*Questions can be directed to:*

**Catholic Mutual Group**
Office: (507) 454-6452

Ryan Christianson
Group Claims & Risk Manager

Ann Zeisel
Administrative Assistant

**Diocese of Winona-Rochester**

Cindy Meyerhofer, Director
Human Resource Office
(507) 858-1250

Amelia Jajowka
HR Employee Benefits
Coordinator (507) 361-3369

MN Department of Labor and Industry
Workers' Compensation Division
(651) 284-5032 or 1-800-342-5354

# First Report of Injury

See Instructions on Reverse Side

Reset

FRO 1

Print in ink or type
Enter dates in MM/DD/YYYY format

DO NOT USE THIS SPACE

| **1. EMPLOYEE SOCIAL SECURITY #** | 2. OSHA case # | 3. Time employee began work on date of injury ☐ am ☐ pm | |
|---|---|---|---|
| **4. DATE OF CLAIMED INJURY** | 5. Time of injury ☐ am ☐ pm | 6. Date of death | # of dependents (if death is related to injury) |
| **7. EMPLOYEE** Name (last, suffix, first, middle) | | 8. Gender ☐ M ☐ F | 9. Marital status ☐ Married ☐ Unmarried |

| 10. Home address | | | 11. Home phone # | 12. Date of birth | 13. Date hired |
|---|---|---|---|---|---|
| City | State | Zip Code | 14. Occupation | 15. Regular department | 16. Apprentice ☐ Yes ☐ No |

| 17. Average weekly wage | 18. Rate per hour | 19. Hours per day | 20. Days per week | Normal work schedule Sun - Sat (S M T W T F S) ☐ ☐ ☐ ☐ ☐ ☐ ☐ | 21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer |
|---|---|---|---|---|---|

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

| 23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.* | 24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.* |
|---|---|

| 25. Did injury occur on employer's premises? ☐ Yes ☐ No<br>Name and address of the place of the occurrence | 26. Date of first day of any lost time | 27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI | |
|---|---|---|---|
| | 28. Date employer notified of injury | 29. Date employer notified of lost time | |
| | 30. Return to work date | 31. RTW same employer ☐ Yes ☐ No | 32. RTW with restrictions ☐ Yes ☐ No |
| 33. Treating physician (name) | 34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated | | |
| 35. Certified Managed Care Organization (if any) | | | |

| 36. **EMPLOYER** Legal name | | | 37. EMPLOYER DBA name (if different) | |
|---|---|---|---|---|
| 38. **Mailing** address | | | 39. Employer FEIN | 40. Unemployment ID # |
| City | State | Zip Code | 41. Employer's contact name and phone # | |
| 42. **Physical** address (if different) | | | 43. Witness (name and phone) - if more than 1 attach a separate sheet | |
| City | State | Zip Code | 44. NAICS code | 45. Date form completed |

| 46. **INSURER** name | | | 51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☐ Insurer ☑ TPA | |
|---|---|---|---|---|
| INDIVIDUAL SELF-INSURANCE | | | BERKLEY RISK ADMINISTRATORS CO, LLC | |
| 47. Insured legal name and FEIN | | | 52. CA address | |
| DIOCESE OF WINONA-ROCHESTER | | | PO BOX 59143 | |
| 48. Policy # (including effective dates) or self-insured certificate # | | | City | State Zip Code |
| W-1007 | | | MINNEAPOLIS | MN 55459 |
| 49. Insurer FEIN | 50. Date insurer received notice | | 53. CA FEIN | 54. CA claim # |
| 410694754 | | | 411887666 | 99-25 |

| 55. To be completed by the **CA**: | Claim type code: | Type of loss code: | Late reason code: | Salary paid in lieu of comp? | Death result of injury? |
|---|---|---|---|---|---|



Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)

## GENERAL INSTRUCTIONS TO THE EMPLOYER

**Employers, not employees,** are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

**Filing this form is not an admission of liability**. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

**If the claim involves death or serious injury (including injuries that later result in death),** you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence, at P.O. Box 64221, St. Paul, MN 55164-0221.

**SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT**

## SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see https://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Lost-or-Misplaced-Your-EIN.
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

## INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR
**(For first reports of injury filed on or after Jan. 1, 2014)**

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at www.dli.mn.gov/WC/Edi.asp.

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury does **not** need to be filed.

***This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198***

**ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.**